HOUSE BILL 610

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HB 470/21 – HGO CF SB 493

By: **Delegates Ruth, Bagnall, Bartlett, Belcastro, C. Branch, Bridges, Charkoudian, Ebersole, W. Fisher, Foley, Forbes, Fraser–Hidalgo, Guyton, Henson, Howell, R. Jones, Lehman, Moon, Palakovich Carr, Solomon, Stewart, Terrasa, Toles, Wilkins, and Williams**

Introduced and read first time: January 31, 2022
Assigned to: Health and Government Operations

A BILL ENTITLED

AN ACT concerning

Public Health – Commission on Universal Health Care

FOR the purpose of establishing the Commission on Universal Health Care to develop a plan for the State to establish a universal health care program to provide health benefits to all residents of the State through a single–payer system; requiring a member of the Commission to be subject to ethics laws and disclose certain other information related to ethics; prohibiting a member of the Commission from being held personally liable for actions taken as a member under certain circumstances; and generally relating to the Commission on Universal Health Care.

BY adding to
Article – Health – General
Section 13–4401 through 13–4403 to be under the new subtitle "Subtitle 44. Commission on Universal Health Care"
Annotated Code of Maryland
(2019 Replacement Volume and 2021 Supplement)

Preamble

WHEREAS, § 1332 of the federal Patient Protection and Affordable Care Act (ACA) allows states to request waivers of key provisions of health care reform, including the requirement to set up a health benefit exchange and provisions relating to premium credits and reduced cost sharing; and

WHEREAS, Under § 1332 of the ACA, a waiver for state innovation may be granted if it covers at least as many people as would be covered under the ACA and provides coverage that is at least as comprehensive and affordable, at no greater cost to the federal government; and

EXPLANATION: **CAPITALS INDICATE MATTER ADDED TO EXISTING LAW.**
[Brackets**]** indicate matter deleted from existing law.

WHEREAS, If an approved waiver does not provide individuals or small businesses with premium tax credits or cost–sharing reductions, a state may receive the federal funding it would have received for these purposes to help implement its approved plan; and

WHEREAS, Extensive work has been done in other states, including New York, Washington, and Maine, developing plans and legislation for state–based universal health care, including funding mechanisms and financial analyses; and

WHEREAS, Multiple jurisdictions in Maryland, including Prince George's County, Montgomery County, and Annapolis, have passed resolutions supporting universal healthcare, some of which specifically mention the creation of a Maryland Commission on Universal Health Care; and

WHEREAS, Maryland should seek to establish a health care program to contain costs and to provide comprehensive, affordable, and high–quality publicly financed health care coverage for all Maryland residents in a seamless manner regardless of income, assets, health status, or availability of other health care coverage; now, therefore,

SECTION 1. BE IT ENACTED BY THE GENERAL ASSEMBLY OF MARYLAND, That the Laws of Maryland read as follows:

Article – Health – General

SUBTITLE 44. COMMISSION ON UNIVERSAL HEALTH CARE.

13–4401.

(A) IN THIS SUBTITLE THE FOLLOWING WORDS HAVE THE MEANINGS INDICATED.

(B) "AFFILIATION" MEANS:

(1) A FINANCIAL INTEREST;

(2) A POSITION OF GOVERNANCE, INCLUDING MEMBERSHIP ON A BOARD OF DIRECTORS, REGARDLESS OF COMPENSATION;

(3) A RELATIONSHIP THROUGH WHICH COMPENSATION IS RECEIVED; OR

(4) A RELATIONSHIP FOR THE PROVISION OF SERVICES AS A REGULATED LOBBYIST.

(C) "COMMISSION" MEANS THE COMMISSION ON UNIVERSAL HEALTH

CARE ESTABLISHED UNDER § 13–4402 OF THIS SUBTITLE.

(D) "COMPENSATION" HAS THE MEANING STATED IN § 5–101 OF THE GENERAL PROVISIONS ARTICLE.

(E) (1) "EXCHANGE" MEANS THE MARYLAND HEALTH BENEFIT EXCHANGE, ESTABLISHED AS A PUBLIC CORPORATION UNDER § 31–102 OF THE INSURANCE ARTICLE.

(2) "EXCHANGE" INCLUDES:

(I) THE INDIVIDUAL EXCHANGE; AND

(II) THE SMALL BUSINESS HEALTH OPTIONS PROGRAM (SHOP EXCHANGE).

(F) "FINANCIAL INTEREST" HAS THE MEANING STATED IN § 5–101 OF THE GENERAL PROVISIONS ARTICLE.

(G) "REGULATED LOBBYIST" HAS THE MEANING STATED IN § 5–101 OF THE GENERAL PROVISIONS ARTICLE.

13–4402.

(A) THERE IS A COMMISSION ON UNIVERSAL HEALTH CARE.

(B) THE COMMISSION CONSISTS OF THE FOLLOWING MEMBERS:

(1) THE SECRETARY, OR THE SECRETARY'S DESIGNEE, AS AN EX OFFICIO MEMBER OF THE COMMISSION;

(2) FOUR MEMBERS APPOINTED BY THE GOVERNOR, WITH THE ADVICE AND CONSENT OF THE SENATE;

(3) THREE MEMBERS APPOINTED BY THE PRESIDENT OF THE SENATE; AND

(4) THREE MEMBERS APPOINTED BY THE SPEAKER OF THE HOUSE.

(C) FROM AMONG ITS MEMBERS, THE COMMISSION SHALL ELECT A CHAIR AND VICE CHAIR.

(D) THE DEPARTMENT SHALL PROVIDE STAFF FOR THE COMMISSION.

(E) IN APPOINTING MEMBERS UNDER SUBSECTION (B) OF THIS SECTION, THE APPOINTING AUTHORITY SHALL:

(1) ENSURE THAT THE APPOINTEE HAS DEMONSTRATED AND ACKNOWLEDGED EXPERTISE IN HEALTH CARE;

(2) CONSIDER THE EXPERTISE OF THE OTHER MEMBERS OF THE COMMISSION AND ATTEMPT TO MAKE APPOINTMENTS SO THAT THE COMMISSION'S COMPOSITION REFLECTS A DIVERSITY OF EXPERTISE IN VARIOUS ASPECTS OF HEALTH CARE; AND

(3) CONSIDER THE CULTURAL, ETHNIC, AND GEOGRAPHICAL DIVERSITY OF THE STATE SO THAT THE COMMISSION'S COMPOSITION REFLECTS THE COMMUNITIES OF THE STATE.

(F) (1) A MEMBER OF THE COMMISSION, WITHIN THE 2–YEAR PERIOD IMMEDIATELY PRECEDING THE MEMBER'S APPOINTMENT AND WHILE SERVING ON THE COMMISSION, MAY NOT BE EMPLOYED, OR HAVE BEEN EMPLOYED, IN ANY CAPACITY BY A CONSULTANT TO A MEMBER OF THE BOARD OF DIRECTORS OF OR OTHERWISE BE A REPRESENTATIVE OF:

(I) A HEALTH CARE PROVIDER;

(II) A HEALTH CARE FACILITY;

(III) A HEALTH CLINIC;

(IV) A PHARMACEUTICAL COMPANY;

(V) A MEDICAL EQUIPMENT COMPANY; OR

(VI) A CARRIER, AN INSURANCE PRODUCER, A THIRD–PARTY ADMINISTRATOR, A MANAGED CARE ORGANIZATION, OR ANY OTHER PERSON CONTRACTING DIRECTLY WITH THOSE PERSONS.

(2) A MEMBER OF THE COMMISSION MAY NOT BE A MEMBER, A BOARD MEMBER, OR AN EMPLOYEE OF A TRADE ASSOCIATION OF HEALTH CARE FACILITIES, HEALTH CLINICS, HEALTH CARE PROVIDERS, CARRIERS, INSURANCE PRODUCERS, THIRD–PARTY ADMINISTRATORS, MANAGED CARE ORGANIZATIONS, OR ANY OTHER ASSOCIATION OF ENTITIES IN A POSITION TO CONTRACT DIRECTLY WITH THE COMMISSION UNLESS THE MEMBER OF THE COMMISSION:

(I) RECEIVES NO COMPENSATION FOR RENDERING SERVICES AS A HEALTH CARE PROVIDER; AND

(II) DOES NOT HAVE AN OWNERSHIP INTEREST IN A HEALTH CARE PRACTICE.

(3) THE PROVISIONS IN THIS SUBSECTION MAY NOT BE CONSTRUED TO PROHIBIT A PHYSICIAN OR NURSE WHO DOES NOT SERVE AS A MEMBER OF A BOARD OF DIRECTORS FOR AN ENTITY LISTED IN PARAGRAPH (1) OF THIS SUBSECTION FROM SERVING AS A MEMBER OF THE COMMISSION.

(G) (1) THE COMMISSION SHALL DETERMINE THE TIMES, PLACES, AND FREQUENCY OF ITS MEETINGS.

(2) FIVE MEMBERS OF THE COMMISSION CONSTITUTE A QUORUM.

(3) ACTION BY THE COMMISSION REQUIRES THE AFFIRMATIVE VOTE OF AT LEAST FIVE MEMBERS.

(H) A MEMBER OF THE COMMISSION:

(1) MAY NOT RECEIVE COMPENSATION AS A MEMBER OF THE COMMISSION; BUT

(2) IS ENTITLED TO:

(I) A PER DIEM RATE AS PROVIDED IN THE STATE BUDGET FOR ATTENDING SCHEDULED MEETINGS OF THE COMMISSION; AND

(II) REIMBURSEMENT FOR EXPENSES UNDER THE STANDARD STATE TRAVEL REGULATIONS, AS PROVIDED IN THE STATE BUDGET.

(I) A MEMBER OF THE COMMISSION SHALL PERFORM THE MEMBER'S DUTIES:

(1) IN GOOD FAITH;

(2) IN THE MANNER THE MEMBER REASONABLY BELIEVES TO BE IN THE BEST INTEREST OF THE STATE; AND

(3) WITHOUT INTENTIONAL OR RECKLESS DISREGARD OF THE CARE AN ORDINARILY PRUDENT PERSON IN A LIKE POSITION WOULD EXERCISE UNDER SIMILAR CIRCUMSTANCES.

(J) (1) (I) A MEMBER OF THE COMMISSION SHALL BE SUBJECT TO TITLE 5, SUBTITLES 1 THROUGH 7 OF THE GENERAL PROVISIONS ARTICLE.

(II) IN ADDITION TO THE DISCLOSURE REQUIRED UNDER TITLE 5, SUBTITLE 6 OF THE GENERAL PROVISIONS ARTICLE, A MEMBER OF THE COMMISSION SHALL DISCLOSE TO THE COMMISSION AND TO THE PUBLIC ANY RELATIONSHIP NOT ADDRESSED IN THE REQUIRED FINANCIAL DISCLOSURE THAT THE MEMBER HAS WITH A HEALTH CARE PROVIDER, A HEALTH CLINIC, A PHARMACEUTICAL COMPANY, A MEDICAL EQUIPMENT COMPANY, A CARRIER, AN INSURANCE PRODUCER, A THIRD–PARTY ADMINISTRATOR, A MANAGED CARE ORGANIZATION, OR ANY OTHER ENTITY IN AN INDUSTRY INVOLVED IN MATTERS LIKELY TO COME BEFORE THE COMMISSION.

(2) ON ALL MATTERS THAT COME BEFORE THE COMMISSION, THE MEMBER SHALL:

(I) ADHERE STRICTLY TO THE CONFLICT OF INTEREST PROVISIONS UNDER TITLE 5, SUBTITLE 5 OF THE GENERAL PROVISIONS ARTICLE RELATING TO RESTRICTIONS ON PARTICIPATION, EMPLOYMENT, AND FINANCIAL INTERESTS; AND

(II) PROVIDE FULL DISCLOSURE TO THE COMMISSION AND THE PUBLIC ON:

1. ANY MATTER THAT GIVES RISE TO A POTENTIAL CONFLICT OF INTEREST; AND

2. THE MANNER IN WHICH THE MEMBER WILL COMPLY WITH THE PROVISIONS OF TITLE 5, SUBTITLE 5 OF THE GENERAL PROVISIONS ARTICLE TO AVOID ANY CONFLICT OF INTEREST OR APPEARANCE OF A CONFLICT OF INTEREST.

(K) A MEMBER OF THE COMMISSION WHO PERFORMS THE MEMBER'S DUTIES IN ACCORDANCE WITH THE STANDARD ESTABLISHED UNDER SUBSECTION (I) OF THIS SECTION MAY NOT BE PERSONALLY LIABLE FOR ACTIONS TAKEN AS A MEMBER IF DONE IN GOOD FAITH, WITHOUT INTENT TO DEFRAUD, AND IN CONNECTION WITH THE ADMINISTRATION, MANAGEMENT, OR CONDUCT RELATED TO THIS SUBTITLE.

(L) A MEMBER OF THE COMMISSION MAY BE REMOVED FOR INCOMPETENCE, MISCONDUCT, OR FAILURE TO PERFORM THE DUTIES OF THE POSITION.

13–4403.

(A) THE COMMISSION SHALL DEVELOP A PLAN FOR THE STATE TO ESTABLISH, ON OR BEFORE JULY 1, 2025, A UNIVERSAL HEALTH CARE PROGRAM TO PROVIDE HEALTH BENEFITS TO ALL RESIDENTS OF THE STATE THROUGH A SINGLE–PAYER SYSTEM.

(B) THE COMMISSION SHALL CONSIDER HOW TO:

(1) INCORPORATE HEALTH CARE EQUITY AS A GOAL OF THE PLAN;

(2) REDUCE HEALTH CARE DISPARITIES; AND

(3) INCREASE HEALTH CARE ACCESS, PARTICULARLY IN URBAN AND RURAL SETTINGS WITH LIMITED ACCESS.

(C) IN DEVELOPING THE PLAN, THE COMMISSION SHALL CONSIDER PLANS AND ANALYSES DONE IN OTHER STATES.

(D) THE HEALTH CARE PROGRAM SHALL BE DESIGNED TO:

(1) PROVIDE COMPREHENSIVE, AFFORDABLE, AND HIGH–QUALITY PUBLICLY FINANCED HEALTH CARE COVERAGE FOR ALL RESIDENTS OF THE STATE IN A SEAMLESS AND EQUITABLE MANNER, REGARDLESS OF INCOME, ASSETS, HEALTH STATUS, CITIZENSHIP OR IMMIGRATION STATUS, OR AVAILABILITY OF OTHER HEALTH CARE COVERAGE;

(2) INCLUDE A BENEFIT PACKAGE COVERING PRIMARY CARE, PREVENTIVE CARE, CHRONIC CARE, ACUTE EPISODIC CARE, REPRODUCTIVE CARE, INCLUDING PREGNANCY, BIRTH CONTROL, AND ABORTION SERVICES, AND HOSPITAL SERVICES;

(3) RECOMMEND HOW, TO THE MAXIMUM EXTENT ALLOWABLE UNDER FEDERAL LAW AND WAIVERS FROM FEDERAL LAW, TO:

(I) ENSURE THAT ALL FEDERAL PAYMENTS PROVIDED IN THE STATE FOR HEALTH CARE SERVICES ARE PAID DIRECTLY TO THE HEALTH CARE PROGRAM; AND

(II) ASSUME RESPONSIBILITY FOR THE BENEFITS AND SERVICES CURRENTLY PAID FOR AND PROVIDED UNDER STATE AND FEDERAL PROGRAMS, INCLUDING THE EXCHANGE, MEDICAID, AND MEDICARE;

(4) INCLUDE HEALTH CARE COVERAGE PROVIDED:

(I) BY EMPLOYERS THAT CHOOSE TO PARTICIPATE; AND

(II) TO STATE, COUNTY, AND MUNICIPAL EMPLOYEES; AND

(5) CONTAIN COSTS BY:

(I) PROVIDING INCENTIVES TO RESIDENTS TO AVOID PREVENTABLE HEALTH CONDITIONS, PROMOTE HEALTH, AND AVOID UNNECESSARY EMERGENCY ROOM VISITS;

(II) ESTABLISHING INNOVATIVE PAYMENT MECHANISMS TO HEALTH CARE PROFESSIONALS, SUCH AS GLOBAL PAYMENTS; AND

(III) REDUCING UNNECESSARY ADMINISTRATIVE EXPENDITURES.

(E) THE PLAN SHALL INCLUDE:

(1) A TIMELINE FOR THE ESTABLISHMENT OF THE HEALTH CARE PROGRAM;

(2) PLANS FOR TRANSITION TO THE HEALTH CARE PROGRAM, INCLUDING:

(I) SUSPENDING OPERATIONS OF THE EXCHANGE TO ENABLE THE STATE TO RECEIVE THE APPROPRIATE FEDERAL FUND CONTRIBUTION IN LIEU OF THE FEDERAL PREMIUM TAX CREDITS, COST–SHARING SUBSIDIES, AND SMALL BUSINESS TAX CREDITS PROVIDED IN THE AFFORDABLE CARE ACT;

(II) HOW TO FULLY INTEGRATE OR ALIGN MEDICAID, MEDICARE, PRIVATE INSURANCE, AND STATE, COUNTY, AND MUNICIPAL EMPLOYEES INTO OR WITH THE HEALTH CARE PROGRAM; AND

(III) A PLAN FOR TRANSITIONING WORKERS DISPLACED BY CHANGES TO THE HEALTH CARE SYSTEM;

(3) A PROPOSED OPERATING STRUCTURE FOR THE HEALTH CARE PROGRAM;

(4) COST PROJECTIONS FOR THE HEALTH CARE PROGRAM AND

RECOMMENDATIONS FOR THE AMOUNTS AND MECHANISMS NECESSARY TO FINANCE THE HEALTH CARE PROGRAM;

(5) (I) A PROPOSED HEALTH BENEFIT PACKAGE TO BE OFFERED IN THE HEALTH CARE PROGRAM; AND

(II) AN ANALYSIS OF WHETHER THE HEALTH CARE PROGRAM SHOULD INCLUDE DENTAL, VISION, HEARING, AND LONG–TERM CARE BENEFITS; AND

(6) RECOMMENDATIONS FOR LEGISLATION REQUIRED TO ESTABLISH THE HEALTH CARE PROGRAM.

(F) THE COMMISSION SHALL SUBMIT TO THE GOVERNOR AND, IN ACCORDANCE WITH § 2–1257 OF THE STATE GOVERNMENT ARTICLE, THE SENATE FINANCE COMMITTEE AND THE HOUSE HEALTH AND GOVERNMENT OPERATIONS COMMITTEE:

(1) ON OR BEFORE JUNE 1, 2023, AN INTERIM PROGRESS REPORT ON THE DEVELOPMENT OF A PLAN TO ESTABLISH THE HEALTH CARE PROGRAM; AND

(2) ON OR BEFORE OCTOBER 1, 2024, THE PLAN TO ESTABLISH THE HEALTH CARE PROGRAM.

SECTION 2. AND BE IT FURTHER ENACTED, That this Act shall take effect June 1, 2022. It shall remain effective for a period of 4 years and 1 month and, at the end of June 30, 2026, this Act, with no further action required by the General Assembly, shall be abrogated and of no further force and effect.